STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155331	A. BUILDING 00 B. WING	07/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF VALPARAISO	3405 N CAMPBELL RD VALPARAISO, IN46385

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F0000	This visit was for the Investigation of Complaint # IN00093820. Complaint # IN00093820-Substantiated, Federal/State deficiencies related to the allegations are cited at F241 and F246. Survey dates: July 25, 26, and 27, 2011 Facility number: 000224 Provider number: 155331 AIM number: 100267700 Survey team: Toni Krakowski, RN Census bed type: SNF: 20 SNF/NF: 77 Total: 97 Census payor type: Medicare: 25 Medicaid: 59 Other: 13 Total: 97 Sample: 5 Supplemental sample: 4 These state findings are cited in accordance with 410 IAC 16.2.	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed 8/1/11 by Jennie Bartelt, RN.			
F0241 SS=E	The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on interview and record review, the facility failed to provide dignified care by responding to residents' request for assistance. This deficient practice affected 3 of 5 residents (#B, #C, #F) reviewed for call lights in the sample of 5 and 3 of 4 residents (#G, #I, #J) in the supplemental sample of 4. Findings include: Residents #F, #G, #I, and #J were identified as alert, oriented, and interviewable by LPN #3 during initial tour of the facility on 7/25/11 at 9:15 A.M. 1. During a telephone interview on 7/25/11 at 2:20 P.M. a family member indicated Resident #C rarely had a call light to summon assistance from facility staff. "It was always out of reach." She further indicated Resident #C's roommate, who no longer lived at the facility, attempted to summon staff to assist	F0241	1. The complaint survey does not identify specific residents affected. Please see response to #2.2. As any resident has the potential to be affected, the Director of Nursing requested permission from the Resident Council President to hold a Resident Council meeting on Thursday, August 11, 2011 at 10:00 am. Residents were informed of the meeting request by Activity staff and encouraged to attend. Seventeen residents attended and interacted with the Director of Nursing who spoke about call light issues and the action plan being developed by the facility to address concerns identified in the survey. All residents present were asked to contribute their thoughts about the response to call lights. A copy of the Resident Council minutes and educational training materials discussed are attached.3. Education is being provided by each facility department head and/or the Staff Development Coordinator by 8/17/2011 for facility staff in each department	08/19/2011

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	Resident #C by using the call light, but "Staff would come in, turn the (call) light off and say they would be back, but not come back in." Review of Resident #C's clinical record on 7/25/11 at 2:15 P.M., indicated diagnoses of, but not limited to, abnormality of gait and muscle weakness. 2. During an interview with Resident #J on 7/26/11 at 10:05 A.M., she indicated she had an occasion when she activated her call light for assistance to the bathroom and the CNA (certified nursing assistant) responded and told her she had too much to do, turned off her light and left. When queried if she put her call light back on, Resident #J stated, "I wheeled down the hall and found someone else to toilet me." 3. Resident #I indicated in an interview on 7/26/11 at 10:55 A.M., "I'm supposed to do as much as possible for myself so when I put the (call) light on, I think they don't hurry because they want me to do it. They tell me, 'We know you're moving when your light is on.' They have come in, turned the light off and not returned because they were busy. I can't recall who it was, but there has been more than one." 4. During an interview with Resident #G		specific to ensuring the placement of call lights in reach in resident rooms and responding to call lights with guidelines for appropriate action to take if unable to resolve a resident concern when answering the call light. The facility management team will be re-educated on their participation in the Guardian Angel program by the Administrator or designee by 8/15/2011. Implementation of that program focuses upon each manager maintaining contact with a specific group of residents to aid in eliciting and responding to concerns regarding care within the facility. Initial contact with residents/responsible parties will be attempted by no later than 8/19/2011 and will continue at a minimum of once per month per six months. Concerns identified will be forwarded to the Administrator or designee for attention and trending data accumulated. Posters focusing attention on the proper placement/response to call lights will be conspicuously placed in staff break areas by 8/19/2011.4. Administrative staff will be assigned to walking observation rounds in all resident rooms three times per week for six months starting on 8/17/2011. Each manager will be responsible for a designated group of residents identified by room number. The staff members will adapt their rounds to include observation of	

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	on 7/27/11 at 9:45 A.M., she indicated it doesn't do any good to use your call light. "You squeeze your call light and no one comes." She indicated she uses her wheel chair to get herself to the bathroom when no one responds to the call light. "I have a problem when they (staff) push my wheel chair out of reach." She indicated she had to make her way to her wheel chair by clinging to objects along the perimeter of her room until she was able to reach it. "I thought maybe I was the only one who had a problem with the call light, but just this morning the ladies at my table were complaining they had the same problem." 5. Resident #B's clinical record was reviewed on 7/26/11 at 10:15 A.M. and indicated diagnoses of, but not limited to, anxiety state, osteoarthrosis, and spinal stenosis. Resident #B's family member indicated in an interview on 7/27/11 at 10:15 A.M., that there have been times when the call light response has been a problem. "I know they get busy. After a while, I stand in the doorway and wait for staff to come by and I call them into my mother's room." She further indicated she has waited as long as 45 minutes. "On Saturday, my cousin was visiting my mother and found her sitting up in her chair. She put the call light on at 6:00		call light placement and call light response interviews. In addition, the ongoing Call Light Audits will be amended as of 8/15/2011 to include questions regarding resident satisfaction with call light response. Copy attached. Results of these audits will be forwarded to the Administrator or designee for follow-up and the Administrator or designee will report these findings at the monthly Performance Improvement Committee meetings where action plans will be developed for any negative trends.	

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	P.M. and when I called my mother that evening she told me they didn't put her to bed until 7:00 P.M." 6. During interview with Resident # F on 7/27/11 at 2:55 P.M., she indicated she had a difficult time summoning staff. "It doesn't do any good to put your call light on. It takes forever for staff to respond." When queried what she meant by 'forever,' she responded, 45 minutes to an hour." Review of Resident #F's clinical record on 7/27/11 at 3:15 P.M. indicated diagnoses of, but not limited to, rheumatoid arthritis, anxiety state, and paraplegia. During a joint interview with the Administrator and the Director of Nursing on 7/27/11 at 3:50 P.M. they indicated they added an extra CNA at night to assist with resident care. They also indicated all staff is to respond to call lights and perhaps unqualified staff (housekeeping, dietary, maintenance) have responded to the call lights, but failed to relay a need to the staff who are qualified to care for the resident. They both indicated they, themselves, respond to call lights. This Federal tag relates to complaint IN00093820.			

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	3.1-3(t)			
F0246 SS=D	A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation, interview, and record review, the facility failed to ensure call lights were within reach. This deficient practice affected 2 of 5 residents (#C, #E) reviewed for call lights in the sample of 5 and 1 of 4 residents (#H) in the supplemental sample of 4. Findings include: Residents #E and #H were identified as alert, oriented, and interviewable by LPN #3 during initial tour of the facility on 7/25/11 at 9:15 A.M. 1. During a telephone interview on 7/25/11 at 2:20 P.M. a family member indicated Resident #C rarely had a call light to summon assistance from facility staff. "It was always out of reach." She further indicated Resident #C's roommate, who no longer lived at the facility, attempted to summon staff to assist	F0246	1. The complaint survey does not identify specific residents affected. Please see response to #2.2. As any resident has the potential to be affected, the Director of Nursing requested permission from the Resident Council President to hold a Resident Council meeting on Thursday, August 11, 2011 at 10:00 am. Residents were informed of the meeting request by Activity staff and encouraged to attend. Seventeen residents attended and interacted with the Director of Nursing who spoke about call light issues and the action plan being developed by the facility to address concerns identified in the survey. All residents present were asked to contribute their thoughts about the response to call lights. A copy of the Resident Council minutes and educational training materials discussed are attached.3. Education is being provided by each facility department head and/or the Staff Development	08/19/2011

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	Resident #C by using his/her call light, but "Staff would come in, turn the (call) light off and say they would be back, but not come back in." Review of Resident #C's clinical record on 7/25/11 at 2:15 P.M., indicated diagnoses of, but not limited to, abnormality of gait and muscle weakness. 2. Resident #E's clinical record was reviewed on 7/27/11 at 11:50 A.M. and indicated diagnoses of, but not limited to, fractured left leg, muscle weakness, and seizure disorder. During observation of Resident #E on 7/27/11 at 1:00 P.M., she was observed sitting in her wheel chair in her room. She was eating her lunch and was alone in the room. Her call light was attached to the bed rail on the opposite side of the bed and was well out of her reach. When queried as to what she would do if she needed to summon the nurse, she responded, "I would hope." 3. Resident #H was observed sitting alone in her room eating her lunch. She was up in her wheel chair and had a bedside table pushed up to the front of her. Her call light was clipped to the privacy curtain on the opposite side of her bed. When queried how she would		Coordinator by 8/17/2011 for facility staff in each department specific to ensuring the appropriate placement of call lights in reach in resident rooms and responding to call lights, with guidelines for appropriate action to take if unable to resolve a resident concern when answering the call light. The facility management team will be re-educated on their participation in the Guardian Angel program by the Administrator or designee by 8/15/2011. This policy is attached. Implementation of that program focuses upon each manager maintaining contact with a specific group of residents to aid in eliciting and responding to concerns regarding care within the facility. Initial contact with residents/responsible parties will be attempted by no later than 8/19/2011 and will continue at a minimum of once per month for six months. Concerns identified will be forwarded to the Administrator or designee for attention and trending data accumulated. Posters focusing attention on the proper placement/response to call lights will be conspicuously placed in staff break areas by 8/19/2011.4. Administrative staff will be assigned to walking observation rounds in all resident rooms three times per week for six months starting on 8/17/2011. Each manager will be responsible for a designated group of residents	

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	summon help if she needed to, she stated, "I guess I would have to yell." During a joint interview with the Administrator and the Director of Nursing on 7/27/11 at 3:50 P.M. they indicated they added an extra CNA at night to assist with resident care. They also indicated all staff is to respond to call lights and perhaps unqualified staff (housekeeping, dietary, maintenance) have responded to the call lights, but failed to relay a need to the staff who are qualified to care for the resident. They both indicated they, themselves, respond to call lights. This Federal tag relates to complaint IN00093820. 3.1-3(v)(1)		identified by room number. The staff members will adapt their rounds to include observation of call light placement and call light response interviews. In addition, the ongoing Call Light Audits will be amended as of 8/15/2011 to include questions regarding resident satisfaction with call light response. Copy attached. Results of these audits will be forwarded to the Administrator or designee for follow-up and the Administrator or designee will report these findings at the monthly Performance Improvement Committee meetings where action plans will be developed for any negative trends. These audits will be done three times per week for six months. All concerns and audit data are to be forwarded to the Administrator or designee for follow-up and the Administrator or designee will report these findings at the monthly Performance Improvement Committee meetings where action plans will be developed for any negative trends.This is my credible allegation	